STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001081	A. BUILDING 00 B. WING	08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL INDIANA ORTHOPEDIC SURGERY CENTER LLC	3600 W BETHEL AVENUE MUNCIE, IN47304

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S0000	The visit was for a licensure survey. Facility Number: 010493 Survey Date: 08-22-11 to 08-24-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Karilyn Tretter, RN Public Health Nurse Surveyor QA: claughlin 08/29/11	S0000		
S0408	410 IAC 15-2.5-1(d) (d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on policy/procedure review, personnel file review and interview, the facility failed to follow it's policy regarding training and professional improvement involving their	S0408	Changed Policy AG-PERS-3 #5 to read "The registered nurse assigned as infection controll coordinator shall attend at least	09/15/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Infection Control Coordinator (P#2). Findings included: 1. During policy/procedure review on 8/22/2011 at 1400: Central Indiana Orthopedic Surgery Center, LLC Policy/Procedure Statement "Training and Professional Improvement", Document No: AG-PERS-3, Page 1 of 2, under Policy: 5. "The registered nurse assigned as infection control coordinator shall attend at least one conference each year covering infection control issues." 2. During personnel file review on 8/22/2011 at 1545: Review of P#2's file contained no documentation of having attended an infection control conference in 2010 or to date in 2011. 3. During interview on 8/23/2011 at 1100: P#2 stated that he/she had not attended any infection control conferences in 2010 or so far in 2011.		one conference/seminar/webinar/training each year covering infection control issues."No clients were affected.The following information provided to surveyor:5/20/10 Infection control coordinator attended conference: "Infection Control in the ASC."12/21-22/10 Infection control coordinator conducted Bloodborne pathogen training for approximately 200 employees.5/2/11 Infection control coordinator completed Excellentia Advisory Groups "Intro to Infection Control" 1 CEU credit completed.8/16/11 Infection control coordinator completed AORN webinar "Increase in sharp injuries in surgical setting". Duration - 1 hour.8/16/11 Infection control coordinator completed AORN webinar "Decreasing surgical rate infections". Duration - 1 hour 30 minutes.For ease of documentation, a spreadsheet was made for Infection Control Coordinator to log staff inservices, conferences, seminars, webinars, & training.Director of Surgery added to QI Tool for annual completion "Infection Control Coordinator Annual Education" with certificate of completion.Director of Surgery added to QI Tool for quarterly completion "Infection Control Coordinator Inservice Completed".Inserviced Infection Control Coordinator on new forms and organization of record	

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			keeping on 9/14/11.Surgery Director, Infection Control Coordinator, and QI/MAC Committee will be responsible for on-going quarterly monitoring.Approved by MAC & Board 9/15/11	
S0640	410 IAC 15-2.5-3(e)(1) (e) All entries in the medical record must be as follows: (1) Legible and complete. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that patient records were complete for 6 of 13 records reviewed (pts. N1, N2, N3, N7, N10, and N12). Findings: 1. at 10:45 AM on 8/23/11, review of the policy and procedure "Creating a Medical Record", Document No: MR-CREA-2, indicated: a. in section 4. (under "Policy"), it read: "...All entries are to be legible and complete." 2. review of patient medical records through out the survey process of 8/22/11 to 8/24/11, indicated: a. pt. N1: A. had check marks related to whether the patient had executed an Advance Directive in both "yes, executed; on chart"	S0640	Inservices & Training on documentation completed at staff meeting on 9/9/11.No clients were affected.Director of Surgery inserviced & trained staff on chart auditing and making sure all entries are legible and complete at a staff meeting on 9/9/11.Expanded current quarterly chart audit to ensure accuracy and completion of documentation with special attention to the following items:* Advance Directives* Discharge Blood Pressure* Using Complete Date (month, day & year)* PACU 1 or 2 check boxes* Times of Vital SignsDirector of Surgery will conduct a chart audit in 30 days that will be completed by 10/10/11 and reported to MAC/QI on 10/18/11. Monitoring will be ongoing using this expanded chart audit tool.Surgery Director, Internal Medical Record Auditor, and QI/ MAC will be responsible for on-going quarterly monitoring.	09/09/2011

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	and in the box "no, not executed"--making it unclear what the patient's status was B. was lacking a discharge blood pressure at 1255 on 9/29/10 in the vital signs section on the "Post Anesthesia Care Record" form (page 1) b. pt. N2 was lacking a year on the "Routine Spine Orders" form, where it reads: "9/24" in both the Pre-op and Post op order section c. pt. N3 was lacking documentation on the "Post Anesthesia Care Record" form (page 1) as to whether the patient was in PACU (post anesthesia care unit) 1 or 2 (no box was checked) d. pt. N7 was lacking a time of vital signs (second set) in the vital signs section on the "Post Anesthesia Care Record" form (page 1) e. pt. N10 was lacking documentation on the "Post Anesthesia Care Record" form (page 1) as to whether the patient was in PACU 1 or 2 (no box was checked) f. pt. N12 was lacking a year on the "Routine Spine Orders" form, it reads: "7/2" in the Pre-op order section (procedure was canceled, so no post op orders needed) 3. interview with staff member NA at 4:15 PM on 8/23/11 indicated there is missing documentation in medical records as listed in 2. above.			

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S0646	410 IAC 15-2.5-3(e)(3) All entries in the medical record must be as follows: (3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule. Based on policy and procedure review, patient medical record review, and staff interview, the medical staff failed to authenticate and date practitioner orders in 9 of 13 medical records reviewed (N2, N4, N5, N6, N8, N9, N11, N12, and N13). Findings: 1. at 10:45 AM on 8/23/11, review of the policy and procedure "Creating a Medical Record", Document No: MR-CREA-2, indicated: a. in section 4. (under "Policy") it read: "Each provider will accurately record the care given to patients in a timely manner and will authenticate each entry by signing (or initialing) and dating their medical record entries, noting their professional license (MD, DO, RN)..." (medical doctor, doctor of osteopathy, registered nurse) 2. review of patient medical records through out the survey process of 8/22/11	S0646	1 & 2Changed Policy MR-CREA-2 #4 to read "Each provider will accurately record the care given to patients in a timely manner and will authenticate each entry by signing (or initialing) and dating their medical record entries. All entries are to be legible or verifiable and complete within 30 days from the date of the procedure." Deleted from policy MR-CREA-2 was the statement "noting their professional license (MD, DO, RN)".No clients affected.Director of Surgery inserviced staff at a staff meeting on 9/9/11.Director of Surgery will institute a format change to the Physician Order Sheet to include date as well as signature.Director of Surgery will inform each physician of need to include date as well as their signature on their orders.Reminder posted in doctor's dictation and doctor's dressing room that states: "When signing Physician Orders you need to write the date, including the year per State Board	09/15/2011

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	to 8/24/11, indicated: a. pts. N2, N4, N5, N6, N8, N12, and N13 had authentication of pre printed pre and post op standing orders that were authenticated by the practitioner, but lacked a noting of their professional license and the date of authentication b. pt. N9: A. had the pre op orders authenticated, but lacked a noting of the practitioner's professional license and the date of authentication B. lacked any authentication of standing post op orders dated 6/13/11 c. pt. N11 lacked any authentication of standing pre op orders dated 10/8/10 3. interview with staff members NA and NB at 10:45 AM on 8/23/11 indicated: a. the facility has no medical staff rules and regulations b. the facility has no policy related specifically to standing orders and how they are to be authenticated, except for the policy listed in 1. above c. the patient medical records, as listed in 2. above, are lacking professional license documentation with authentication, and are lacking a date of authentication, as required per policy d. physician authentication of orders is lacking for pts. N9 and N11 as stated in 2. above		requirement tag Q0646".Expanded chart audit to ensure accuracy and completion of documentation with special attention to the following items:* Date on Pre-op Physician Orders* Signature on Pre-op Physician Orders* Date on Post-op Physician Orders* Signature on Post-op Physician OrdersDirector of Surgery will conduct a chart audit in 30 days that will be completed by 10/10/11 and reported to MAC on 10/18/11.Approved by MAC & Board by 9/15/113 a. The facility has medical staff rules and regulations: AG-GOVN-3 b. Policy created MR-CREA-8 Standing Ordersc. All physicians informed on dating and signing their orders.d. Both charts for pts. N9 & N11 were the same physician. Director of Surgery notified physician on 9/13/11 and informed on dating and signing his orders. Approved by MAC & Board 9/15/11Surgery Director, Internal Medical Record Auditor, and QI/ MAC will be responsible for on-going quarterly monitoring.	

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S0782	410 IAC 15-2.5-4(b)(3)(O) These bylaws and rule must be as follows: (3) Include, at a minimum, the following: (O) A provision for personnel authorized to take a verbal order. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that nursing and medical staff followed the policy related to verbal orders for 1 of 2 patient records who had verbal orders written (pt. N9). Findings: 1. at 9:00 AM on 8/23/11, review of the policy "Verbal Orders", Document No: MR-CREA-3, indicated: a. under "Policy", it read: "1. The nurse accepting the verbal order shall write in the medical record the date, time, person giving the order, the order itself and the person implementing the orders. 2. The nurse receiving the verbal order shall read it back to the prescribing physician to verify that the order is correct. 3. The person implementing the order shall sign and date the implementation. 4. The person giving the order shall sign, date	S0782	Nursing staff read policy on Verbal Orders MR-CREA-3 .No clients were affected.Director of Surgery inserviced staff on policy and procedures for verbal orders on 9/9/11.Director of Surgery tested Prep/PACU nurses on proficiency in verbal order scenarios on 9/13/11.Director of Surgery informed the medical staff that verbal orders must be signed, dated and timed within 30 days of giving the order.QI Study to be conducted in 30 days that will be completed by 10/10/11 and reported to QI on 10/18/11. QI criteria will be >= 95% to determine whether further monitoring is necessary or if the monitoring can be stopped.Surgery Director, Internal Medical Record Auditor, and QI/ MAC will be responsible for monitoring.	09/13/2011

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	and time the order within 30 days." 2. review of patient medical records through out the survey process of 8/22/11 to 8/24/11, indicated: a. pt. N9 had verbal orders written on the "Anesthesia Orders" form (with an implementation date of 11/24/10) by the nurse that lacked: A. a date and time that the order was received B. documentation by the nurse of a read back and verify of the order C. documentation, with a signature and date, of the implementation of the order D. a time of the authentication of the orders by the physician 3. interview with staff members NA and NB at 10:45 AM on 8/23/11 indicated that: with review of the verbal order written for pt. N9 on 6/13/11, the verbal orders policy was not followed			
S0906	410 IAC 15-2.5-5(a)(2) (a) Patient care services must require the following: (2) That personnel with appropriate training are available at all times to handle possible emergencies involving patients of the center. Based on policy/procedure review, personnel	S0906	Changed policy AG-PERS-3 #9 to read "The Surgery Director will	09/20/2011

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	file review and interview, the facility failed to ensure that personnel with appropriate training are available at all times to handle emergencies at the ASC for 1 of 10 (P#7) RNs. Findings included: 1. During policy/procedure review on 8/22/2011 at 1415: Central Indiana Orthopedic Surgery Center, LLC Policy/Procedure Statement "Training and Professional Improvement", Document No: AG-PERS-3, Page 1 of 2, under Policy: 9. "...all staff who have direct patient care to maintain CPR certification and all RN staff to maintain ACLS certification." 2. During personnel file review on 8/23/2011 at 0930, documentation indicated that P#7's ACLS certification had expired on 8/1/2011. 3. During interview with Director of Surgery (P#10) on 8/23/2011 at 1500, he/she stated that P#7's ACLS was expired and that he/she is signed up for ACLS recertification on 9/15/2011. P#10 also stated that P#7 is a PRN employee and is not on the current schedule.		provide scheduled time for all staff who have direct patient care to maintain CPR certification and all RN staff to maintain ACLS certification. The certification must be by a Certified CPR/ACLS Instructor, respectively. If either CPR or ACLS is expired the staff member will have 30 days to complete. The staff member with the expired certification is only allowed to work if there is another staff member in their assigned area with current certification. If certification is not completed in 30 days, the staff member is not allowed to work until proof of certification is received."No clients were affected.Director of Surgery notified staff of proposed policy change at a staff meeting on 9/9/11.Continue to monitor spreadsheet that gives staff's expiration dates of CPR & ACLS.Approved by MAC & Board on 9/15/11.Policy AG-PERS-3 posted on communication board for staff on 9-15-11.Surgery Director and Adminisrtative Assistant will be responsible for on-going monitoring of the certification spreadsheet.	

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S1020	410 IAC 15-2.5-6(3)(D) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record. Based on document review and interview, the facility failed to have a policy/procedure ensuring medication errors would be documented in the patient record. Findings: 1. The policy/procedure Medication Errors (approved 04-28-11) failed to indicate the error will be documented in the patient record when a medication was administered to the wrong patient or incorrect medication was administered to a patient. 2. During an interview on 08-23-11 at 1445 hours, staff #22 confirmed the policy/procedure lacked the requirement to document in the patient record.	S1020	Changed policy CS-PHAR-5 #1 to include excerpt from CS-NURS-14.022 to read "Any person who commits, witnesses or discovers a medication or related errors, as defined below, must report the incident on an incident report (QI-QUAL-2). Report any error or adverse reaction immediately and document in the patient's record accordingly. Our purpose is not to place blame for a medication error, but rather to use the incident reporting and quality improvement process to allow us to improve our systems, thereby improving patient safety."No clients were affected.Director of Surgery inserviced staff at a staff meeting on 9/9/11.Approved by MAC/Board by 9/15/11.Surgery Director will be responsible for on-going quarterly monitoring by reviewing any medication errors on the incident reports.	09/15/2011

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